PRINTED: 10/07/2013 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		003674	B. WING		10/02/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CRAWFORDSVILLE BICKFORD COTTAGE 100 BICKFORD LN						
CRAWFORDSVILLE, IN 47933						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TION SHOULD BE COMPLETE DATE	
R 000	000 INITIAL COMMENTS		R 000			
	This visit was for a St Survey.	ate Residential Licensure				
	Survey date: October 2, 2013					
	Facility number: 0036 Provider number: N/A AIM number: N/A					
	Survey team: Teresa Buske RN-TC Mary Weyls RN Karen Hartman RN					
	Census Bed Type: Residential 26 Total: 26					
	Census Payor Type: Other 26 Total: 26					
	Sample: 11					
		rd Cottage was found to be 0 IAC 16.2 in regard to the ensure Survey.				
	Quality Review 10/04	I/13 by Lisa McColly				

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE